Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Monarch Pain Care and Rehabilitation

Respondent Name
Commerce & Industry Insurance

MFDR Tracking Number
M4-10-3701-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 12, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient stated above sustained two SEPARATE injuries on January 22, … Both regions require two separate evaluations, two separate therapeutic exercises, two separate services entirely."

Amount in Dispute: $634.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No written position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 23 - 30, 2009 January 5 – 14, 2010	Physical Therapy	$634.02	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133. 250 sets out guidelines for reconsideration for payment of medical bills
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – Duplicate claim/service
   - 45 – Chares exceed your contracted/legislated fee arrangement
   - W1 – Workers Compensation State Fee Schedule Adjustment

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute??
2. What is the applicable rule pertaining to corrected claims.
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. The carrier denied the services in dispute as, 18 – "Duplicate claim/service". 28 Texas Administrative Code §133.250(d) states in pertinent part, "A written request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill; (2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier; (3) include any necessary and related documentation not submitted with the original medical bill to support the health care provider's position; and (4) include a bill-specific, substantive explanation in accordance with §133.3 of this title (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment." Review of the medical bills submitted with requestor's information finds that all medical bills contain the ICD-9 code 847.2 (lumbar sprain). The requestor's position statement states, "The patient stated above sustained two SEPARATE injuries…" there is nothing to support a separate diagnosis was being treated by the medical bills submitted with this dispute. The carrier's denial is supported.
3. The requirements of Rule 133.250(d) were not met. Specifically there was no separate and distinct condition reported on the medical bills to support that a different area of the body was being treated. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.